TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Clinics of North Texas

Respondent Name
Facility Insurance Corporation

MFDR Tracking Number
M4-17-1904-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied stating that Dr. Barnhart and service is not approved. In the reconsideration I mentioned that they have been paying for claims for this patient and Dr. Barnhart for years. There is no reason that they should deny payment of service now."

Amount in Dispute: $318.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains that Sec. 408.021 requires that all health care must be approved or recommended by the employee's treating doctor. On May 9th, 2014, the claimant's treating doctor became Dr. Lawrence Rains … The dates of service in question involve treatment from a Benny Barnhart M.D. in 2016. There is no referral or authorization of treatment from Dr. Rains to Dr. Barnhart. There is no evidence that the treatment in question was 'approved or recommended' by the claimant's treating doctor. As such the carrier maintains its denial of the charges submitted by Dr. Barnhart."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2016 and August 22, 2016	Evaluation & Management, established patient (99213)	$318.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.021 establishes entitlement to medical benefits.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 242 – Not treating doctor approved treatment.
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

Issues

Are Facility Insurance Corporation's reasons for denial of payment supported?

Findings

Facility Insurance Corporation denied disputed services with claim adjustment reason codes 242 – "NOT TREATING DOCTOR APPROVED TREATMENT," and B7 – "THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE." Texas Labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

Review of the submitted information does not support that the disputed service was approved or recommended by the employee's treating doctor. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	May 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.